



Original Communication

Health screening in police custody

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ABSTRACT

Background: There have been few previous studies on the health needs of police detainees. London's Metropolitan Police Service (MPS) uses health screening procedures which have not yet been evaluated. The objective of this study is to determine the extent of health problems and 'mental vulnerability' in detainees in police custody, and the efficacy of current health screening procedures.

Methods: Custody records from five London Boroughs were reviewed. Prevalence data for health problems and mental vulnerability was obtained from the anonymised records of 307 detainees who were referred to the Forensic Medical Examiner (FME). Data were analysed for the identification of physical and psychiatric morbidity.

Results: Injuries, epilepsy and asthma were the most common physical health problems noted. Drug and alcohol issues were also frequently encountered along with depression and self-harming behaviour and suicidal ideation. Morbidity was lower than that reported in other, interview based studies. Less than 2% of detainees were thought to require an Appropriate Adult to be present during police interview.

Conclusions: A significant amount of health morbidity is present among detainees in police custody. Our findings suggest that current police screening procedures detect only a proportion of this. Further research is warranted to evaluate the effectiveness of health screening in police custody.

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1. Introduction

Individuals held in police custody suffer from a range of physical health problems, mental disorders, and conditions associated with the use of alcohol and drugs. In addition, mental disorder, including learning or cognitive disabilities, can impact on a detainee's functioning in the context of a police interview, necessitating the presence of an Appropriate Adult.¹ Limited healthcare resources make it unfeasible for every new detainee to be assessed by a doctor or health care professional. Police detainees are therefore screened by the custody sergeant in order to identify those who require further assessment by a doctor.

Studies of health screening in prison populations have highlighted high morbidity, but poor detection by routine screening.^{2–6} There is limited research, however, into the incidence of physical or mental health conditions in police detainees, and even less into the efficacy of health screening in this setting. A study of police custody detainees in London in the 1990s found that 1.2% showed signs of schizophrenia, affective disorders, and organic

conditions.⁷ A review of individuals held in police custody overnight prior to attendance at Manchester Magistrates Court reported higher rates, with about 7% having serious mental disorders such as schizophrenia, hypomania and depression.⁸ A more recent survey of police detainees in London estimated that over half had active medical conditions including asthma, diabetes, epilepsy, alcohol and drug dependence and self reported symptoms related to "mental health problems and depression".⁹

Similarly, while it has been estimated that 7% of prisoners have an IQ less than 70,¹⁰ there is little data on the incidence of learning and cognitive disability in those detained in police custody.^{11,12}

In addition to morbidity, deaths in police custody are of great concern, with 20–40 occurring each year in England and Wales.¹³ There are a larger number of 'near miss' incidents, with 121 reported in the Metropolitan Police Service (MPS) area between May 2005 and April 2006.¹⁴ One half of these cases were associated with deliberate self-harm, one-third with drug possession or consumption, and the remaining to medical conditions and the effects of alcohol.

No published research has examined the effectiveness of routine screening to detect the significant rates of morbidity described above, or the efficacy of the medical response when medical or psychiatric conditions are identified.

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The custody health screen currently used by the MPS is typical of that employed by police services elsewhere in the UK. When a detainee comes into custody, a police sergeant in the custody suite is required to enter details relating to a detainee's health and risk on a computer based form. Based on this, the sergeant decides whether a doctor, known in London as a Forensic Medical Examiner (FME), is required. The sergeant also decides whether the detainee is 'mentally vulnerable' and requires the presence of an Appropriate Adult. The efficacy of this screening process has not been evaluated. The current study, which is the first stage in an evaluation and possible revision of the health screening of detainees by the MPS, examines the incidence of a range of health related problems in individuals held in custody.

2. Methods

We surveyed police arrest records from five London Boroughs for evidence of health morbidity. The boroughs were selected to capture diversity within the London Metropolitan area. Consecutive records from custody suites in Wimbledon, Charing Cross, Lewisham, Colindale and Stoke Newington were sampled from 1st week in May 2008, covering weekdays, weekends and night time periods.

The existing health screen for detainees is part of the custody sergeant's overall risk assessment. This process is computerised. The custody sergeant is directed by the program to enter risk and health details in a pre-determined process. When the FME sees a detainee, the consultation is also recorded on the computerised system by the doctor. However, we did not have access to any supplementary data from the FME, such as their own standardised consultation records which were not available on the computer system.

As the researchers did not have direct access to the police computer, custody records were printed off by a member of the custody directorate and relevant data was entered onto a Microsoft Excel spreadsheet by one of the authors (IM). Personal identifiable data was removed from the records. Statistical analyses were carried out using SPSS v17.0 for Windows and Minitab 15 for Windows by both authors.

3. Results

3.1. Sample characteristics

During the period sampled, 646 individuals were taken into police custody across the five custody areas, 307 (47.5%) of whom were seen by the FME. Records of these 307 detainees were examined in detail. The characteristics of this group are shown in Table 1.

3.2. Referral to FME by police staff

Of the 307 detainees referred to the FME, 127 (41%) were documented as requests for assessment of the detainee's "fitness for detention" in police custody or their "fitness for interview". One

Table 1
Sample characteristics of 307 individuals seen by FMEs.

	Total
Mean age (SD)	30.9 (11.6)
Median age	28
Male	252 (82%)
Female	55 (18%)
White British	104 (34%)
White non-British	61 (20%)
Minority ethnic group, British	113 (37%)
Minority ethnic group, non-British	29 (9%)

hundred and forty-four physical health, 113 drug related and 63 mental health associated entries were made by the custody sergeant. The most frequent reason for requesting the FME was to assess alcohol intoxicated detainees (68 referrals), followed by requests for the assessment of injuries (61 referrals).

3.3. Physical health

The most commonly documented physical health problems in the custody records are shown in Table 2. It can be seen that injuries, epilepsy and asthma were the most frequently documented conditions. There were no statistically significant differences between the numbers of cases of these physical health conditions picked up by the FME compared to the custody sergeant, although numbers were low. Other health problems documented in the custody sergeant's record such as headache, chest pain or vomiting did not appear in the doctor's record, although in many of these cases the doctor documented a diagnosis rather than the symptom (for example headache recorded by the sergeant was later documented as a head injury by the FME).

Other reasons for referral to the FME included requests by the detainee to see the doctor without giving a reason (five cases) and four referrals because the detainee reported having recently been in contact with health services and discharged (for example seen in A&E for injuries). Seven detainees were seen by the FME to obtain blood alcohol levels following a positive breath test, and one for the acquisition of intimate samples following an alleged sexual offence.

Twenty-four detainees required hospital treatment for physical health problems. Ten were taken to hospital directly at the time of arrest and were subsequently brought to the custody suite following discharge: three of these individuals had stab wounds, two had suspected seizures, two were suspected of having swallowed drugs, two had head injuries and one had been involved in a road traffic incident. Fourteen detainees were transferred to hospital from custody, either following the risk assessment or having been seen by the FME: six were transferred due to injuries, and the remainder due to suspected acute coronary syndrome (two cases), hyperglycaemia, collapse, laparotomy dehiscence, deep vein thrombosis, suspicion of swallowing drugs and a suspected lower respiratory tract infection.

3.4. Drug and alcohol related issues

A total of 113 individual drug and alcohol problems were recorded by the custody sergeant compared to 202 by the FME. This difference was statistically significant (χ^2 square = 51.683; p = 0.000); alcohol intoxication was documented 111 times by

Table 2
Number of physical health problems documented in the police custody risk assessment and by the FME (n = 307).

	Sergeant	FME
Injury (excluding head injury)	63	70
Epilepsy	12	13
Asthma	20	25
Head injury	11	18
Musculo-skeletal problem	10	20
Diabetes mellitus	5	7
Hypertension	6	7
Heart disease	7	10
Pregnancy (n = 55)	4	4
Deep vein thrombosis	3	3
Abdominal pain	3	9
Human immunodeficiency virus+	1	1
Hepatitis B/C	4	3

the FME but only 78 times by the police sergeant (chi square = 8.324; $p = 0.004$). Thirteen detainees were felt to be at risk of acute alcohol withdrawal by the FME compared to three identified by the sergeant (chi square = 6.417; $p = 0.011$). Similarly, the risk of drug withdrawal was detected more frequently by the FME (20 cases) than by the sergeant (12 cases) (chi square = 2.110; $p = 0.146$). A further 22 cases of unspecified drug use were present in the custody sergeant's notes but not recorded in the doctors' documentation.

3.5. Mental health

Mental health issues featured frequently in the police records, with depression, previous self-harm and suicidal ideation most commonly documented. Many more individuals were assessed as having mental health difficulties by the FME than were identified by the custody sergeant. Table 3 shows the categories of psychiatric disturbance documented. The custody sergeant's records also recorded one case each of anorexia, Post Traumatic Stress Disorder and a detainee who had absconded from an inpatient unit elsewhere in the country whilst detained under the Mental Health Act (1983) that were not documented by the FME. Only five detainees were thought to require further assessment by specialised mental health services, three of whom were assessed under the MHA 1983.

3.6. Appropriate Adults

Sixteen detainees were under the age of 17-years-old, all of whom were referred for an Appropriate Adult to be present during the police interview.

Eleven (1.75%) of the 630 detainees who were over 17 were referred for an Appropriate Adult, of whom eight had been referred to the FME for a decision of whether an Appropriate Adult was required. The reason for referral in these cases was either "mental health problems" or there was no documented reason. No mention was made of intellectual disability, or the need to assess for this.

4. Discussion

There are a number of publications available to assist officers responsible for the welfare of individuals arrested in London. The MPS custody Standard Operating Procedure (SOP)¹⁵ and code-C

of the Police and Criminal Evidence Act (PACE-C)¹ both emphasise the importance of detecting health issues requiring medical attention and the steps to be taken upon their discovery. The referral to the FME of detainees who come into custody directly from hospital is also part of the SOP. The custody sergeant has no discretion in this situation. These publications also highlight the need to assess the risk of suicide, self harm, problematic drug and alcohol use, and to identify vulnerable individuals who require an Appropriate Adult at interview. These factors have also been identified by the Independent Police Complaints Commission as being major contributors to deaths in custody.¹⁶ National guidance is also available with a view to improving the safety of detainees in police custody.¹⁷

We found that injuries are the most frequent physical health problem giving rise to referral for a medical opinion. However, medical conditions such as epilepsy, diabetes and asthma were not uncommon. Our study noted lower prevalences for physical health problems than did a previous study also carried out in London.⁹ While both included only detainees seen by the FME, the earlier study incorporated a structured health interview whereas we relied on the standard custody records of detainees referred by the custody sergeant. While the quality of the documentation within the custody records varied from doctor to doctor, which may account for the lower prevalences in our study, the differences between the studies suggests that the routine custody health screen may be missing significant physical morbidity. Furthermore, it is important to recognise that the data available to the researchers were taken from the MPS computer based notes system. It is commonplace for FMEs to carry their own consultation records which may be more detailed, suggesting that health morbidity is likely to be greater than is suggested by our data. In addition, our data suggest that detainees are more likely to tell the FME than the police sergeant about problematic drug misuse, with important implications for the early identification of detainees at risk of alcohol or drug withdrawal syndromes.

The mental health prevalences we observed were also lower than a study involving individuals detained in police custody overnight and attending Magistrates Court in Manchester the next day.⁸ That study was of consecutive detainees who were interviewed using structured questionnaires to detect psychiatric morbidity. In contrast, our study included cases identified by the custody sergeant, which again suggests that existing health screening protocols are missing significant morbidity.

It is important to be aware of Section 136, Mental Health Act 1983 (as amended by the Mental Health Act [MHA] 2007). This part of the mental health legislation in England and Wales allows a police officer to take a person they suspect of having a mental disorder to a "place of safety" for assessment in preference to the custody suite. In London, the police use local hospital facilities for this purpose, and therefore there were no such cases in our study. Thus, additional potential detainees with mental disorders may have been diverted effectively away from custody.

The situation regarding mental vulnerability, intellectual disability and the need for an Appropriate Adult remains unclear. It is estimated that 2–3% of the UK population has a learning disability.¹⁸ Taken together with the psychiatric prevalence data from the Manchester Magistrates study,⁸ it is likely that the 1.75% of detainees who were thought to require an Appropriate Adult in our survey under represent the real need.

Although our study suggests that health screening in police custody suites fails to detect individuals with health related problems and mental vulnerability, further research is required to determine just how much physical and psychiatric morbidity is actually missed by current procedures.

Table 3
Psychiatric disturbance in 307 detainees.

	Custody sergeant risk assessment	FME records	
Depression	21	40	Chi square 6.751; $p = 0.010$
History of self injury/harm	12	33	Chi square 10.575; $p = 0.001$
Mental health problem (unspecified)	17	12	Chi square 0.905; $p = 0.341$
Recent/ongoing suicidal ideation	5	6	Chi square 0.093; $p = 0.761$
ADHD	3	3	Chi square 0.000; $p = 1.000$
Possible psychotic symptoms	2	5	Chi square 1.301; $p = 0.254$
Bipolar disorder	2	3	Chi square 0.202; $p = 0.653$
Schizophrenia	1	1	Chi square 0.000; $p = 1.000$

5. Conflicts of Interest

None declared.

Ethical Approval

The study was approved by the Newcastle and North Tyneside Research Ethics Committee.

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